STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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K010000		K010000		

A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 10/16/14

Facility Number: 000369
Provider Number: 155530
AIM Number: 100275190

Surveyors: Brett Overmyer, Life Safety Code Specialist

At this Life Safety Code survey, South Shore Health & Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This one story facility with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	including the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 129 with a census of 69 at the time of the survey. Quality Review by Dennis Austill, Life Safety Code Specialist on 10/28/14. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the wooden shed in the back used for maintenance storage.			
K010018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of more than 100 corridor doors were free from	K010018	The facility will ensure that resident room doors latch into their frames. Resident room door identified during the survey has	11/15/2014

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	impediments to closing. This deficient practice affects visitors, staff and 13 residents on the 200 hall. Findings Include: Based on observation with the maintenance director on 10/16/14 between 11:00 a.m. and 3:00 p.m., the resident room 203 door lacked a positive latching mechanism for the door which did not latch into the frame. The Maintenance Director acknowledged the aforementioned deficiency. 3.1-19(b)		been repaired All other resident doors in the facility have been checked to ensure proper functioning No new issues noted. Environmental Director or designee will check all doors in the facility to ensure proper functioning. Audits for door latches will be conducted at least weekly to ensure continued proper functioning. Results of weekly audits will be reported to the QA Team at least monthly or until problem is considered resolved. Problem will be considered resolved when no new issues are identified over a two month period.	
K010029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure doors to 2 of 2	K010029	The facility will ensure that hazardous storage area have self	11/15/2014

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	hazardous storage rooms self closed to prevent the passage of smoke. This deficient practice could affect visitors, staff and 42 or more residents in the Unit 4 and small dining room smoke compartments. Findings include: Based on observation with the maintenance director on 10/16/14 between 11:00 a.m. and 3:00 p.m., door closures were not provided for doors to the Room 405 and 406 which were being used for storage, contained plastics, paper, several 5 gal buckets of acrylic based paint, cardboard, Styrofoam products and 8 bags of Kingsford Charcoal briquette. The maintenance director acknowledged at the time of observation, the door closures were missing. 3.1-19(b)		closing mechanism on the doors. The two rooms identified have had self closing mechanism installed to prevent the spread of smoke during a fire All other storage areas have been checked to ensure that self closing mechanisms are in place and functional. No new issues identified. Environmental Director or designee will audit doors at least monthly to ensure proper functioning. Results of audits will be reported to the QA Team at least monthly or until this problem is considered resolved. Problem will be considered resolved after two consecutive months of no new issues noted.	
K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure two doors in 1 of 1 locked emergency exits were accessible	K010038	The facility will ensure that all exit doors are accessible at all times. The exit doors identified during	11/15/2014

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	at all times. LSC 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice would affect all residents, visitors and staff that reside in the Unit 4 wing. Findings include: Based on observation and interview with the maintenance director on 10/16/14 between 11:00 a.m. and 3:00 p.m., the maintenance director attempted to open the Unit 4 west end egress exit double door. The maintenance director had to push and kick open the one side of the door. The other side of the door was not able to be opened at all. The maintenance director then had to slam the door on several attempts to get the door that opened to close properly. The maintenance director acknowledged the aforementioned deficiency. 3.1-19(b)		the survey have been repaired. Doors are easily opened without effort. All exits have been checked to ensure proper functioning. All doors are functioning properly. Environmental Director or designee will audit doors at least weekly to ensure continued proper functioning. Results of audits will be reported to the QA Team monthly or until problem is considered resolved to ensure continue compliance. Problem will be considered resolved after two months of audits with no new issues noted.	
K010044 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5			

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	Based on observation and interview, the facility failed to ensure 2 of 4 fire door sets would latch into the door frame. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closures complying with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-.1.2 requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires all fire doors to be closed and latched at the time of a fire. This deficient practice affects any resident, visitor, and staff using the Units 2 & 3 and the Main Dining room.. Findings include: 1) Based on observation and interview on 10/16/14 between 11:00 a.m. and 3:00 p.m. with the maintenance director, the fire door with a 1 ½ hour fire resistance rating and separated the existing Unit 2 Hall from the Main Dining Room, which had a positive latching mechanism for the door but failed to latch into the frame. 2) the fire door with a 1 ½ hour fire resistance rating and separated the existing Unit 3 Hall from the Main Dining room, which had a positive latching mechanism for the door but failed to latch into the frame. This was verified by the maintenance director at the time of observation.	K010044	The facility will ensure that fire doors latch into the door frame as needed. The two doors identified during the survey have been repaired. Subsequent audits have shown that the doors are working properly. All fire doors have been checked and adjusted for efficiency and effectiveness as smoke barriers. Environmental Director or designee will ensure proper functioning of smoke doors during monthly fire drills which would occur at least twice a month. The results of fire drills will be reported to the QA Team at least monthly. This will be a on-going QA monitoring issue.	11/15/2014

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	3.1-19(b)			
K010046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation, record review and interview, the facility failed to provide complete documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 21 of 21 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect all occupants. Findings include: Based on observation, record review and interview between 11:00 a.m. and 3:00 p.m., on 10/16/14 with the maintenance director: the facility could not produce	K010046	The facility will ensure that documentation is available to show testing of the smoke detectors throughout the facility. All smoke detectors have been inspected and are fully functional. Testing of the detectors was completed during survey. One was found not to be working properly and was replaced during the survey. Environmental Director or designee will conduct testing of the smoke detectors at least weekly. Batteries will be replaced throughout the facility on 10/31/2015 per policy. Results of audits will be reported to QA Team at least monthly on an on-going basis. The facility will ensure that testing of battery operated lights is conducted for 1/1/2 hours at least annually. The system was recently tested during a power outage on 10/31/2014 and during routine testing. The power outage lasted for 3 hours and emergency lighting was engaged during the entire	11/15/2014

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	documentation to show the battery back-up lights had been inspected on a monthly basis and could not produce the documentation for the 11/2 hour yearly test. They maintenance director acknowledged the aforementioned deficiencies. 3.1-19(b)		process. Environmental Director documented testing of the lighting during the power outage. The QA Team will review testing intervals at least monthly or until problem is considered resolved. Problem will be considered resolved when no new issues are identified within a two month period.	
K010052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation, record review, and interview; the facility failed to ensure there was documentation for the testing of 49 of 49 battery operated smoke detectors. LSC 9.6 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. NFPA 72, 7-3.3 requires single station detectors installed in other than one- and two family dwelling units shall be tested and maintained in accordance with Chapter 7. This deficient practice could affect all residents, as well as staff	K010052	The facility will ensure that documentation is available to show testing of the smoke detectors throughout the facility. All smoke detectors have been inspected and are fully functional. Testing of the detectors was completed during survey. One was found not to be working properly and was replaced during the survey. Environmental Director or designee will conduct testing of the smoke detectors at least weekly. Batteries will be replaced throughout the facility on 10/31/2015 per policy and during routine testing. Results of audits	11/15/2014

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	and visitors in the facility. Findings include: Based on observation, record review and interview of the facility's Fire and Safety book on 10/16/14 between 11:00 a.m. and 12:00 p.m., with the maintenance director; the annual fire alarm system inspection report by a third party vendor dated 07/24/14 did not include the testing of battery operated smoke detectors. Upon interview with the maintenance director, he thought the 3rd party vendor for the fire alarm system was doing the inspection, so he never documented his inspections for the forty nine battery-operated smoke detectors. The maintenance director acknowledged there was no documentation available to show when the battery operated smoke detectors were checked and when the batteries were replaced on all forty nine smoke detectors. 3-1.19(b)		will be reported to QA Team at least monthly on an on-going basis.	
K010054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested			

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	in accordance with the manufacturer's specifications. 9.6.1.3 Based on observation, record review and interview, the facility failed to ensure 1 of 1 smoke detectors had been replaced as required. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. This deficient practice affects any resident, staff or visitor using the small dining room. Findings include: Based on observation, record review and interview between 11:00 a.m. and 12:00 p.m. on 10/16/14, with the maintenance director; On the third party vendor report dated 07/24/14 and titled "sensitivity testing", the smoke detector located in the small dining room was found outside the listed and marked sensitivity range and therefore failed the sensitivity testing. The maintenance director acknowledged that the smoke detector failed and said at the time of record review, he had no other documentation to provide to show the smoke detector had been repaired or	K010054	The facility will ensure that documentation is available to show testing of the smoke detectors throughout the facility. All smoke detectors have been inspected and are fully functional. Testing of the detectors was completed during survey. One was found to not be working properly and was replaced during the survey. Environmental Director or designee will conduct testing of the smoke detectors at least weekly. Batteries will be replaced throughout the facility on 10/31/2015 per policy or during routine testing. Results of audits will be reported to QA Team at least monthly on an on-going basis.	11/15/2014

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	replaced. 3.1-19(b)			
K010068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for staff in the basement. Findings include: Based on an observation and interview with the maintenance director on 10/16/14 between 11:00 a.m. and 3:00 p.m., the basement laundry room had 2 fuel fired dryers with no fresh air intake. This was acknowledged by the maintenance director at the time of observation.	K010068	The facility will ensure that the laundry area has adequate fresh air intake. Upon observation, it is noted that fresh in-take is available in the laundry area. Access has been restored. Carbon Monoxide detectors are in place for safety. No other areas identified in the facility that would present this type of problem. In-service conducted with laundry employees to ensure that fresh air flow is not blocked in the future. Environmental Director or designee will monitor fresh air intake at least weekly to ensure continued compliance. Results of audits will be reported to the QA Team on a monthly basis or until problem is considered resolved. Problem will be considered resolved when no new issues are identified for two consecutive months.	11/15/2014

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	3.1-19(b)			
K010069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation, record review and interview, the facility failed to ensure fire extinguishing equipment for 1 of 1 range hoods was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-2.1 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. Furthermore, NFPA 96, 8-2.1.1 requires actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, fire-actuated dampers, etc., shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice affects occupants of the kitchen where 3	K010069	The facility will ensure that fire suppression system is inspected at least every six months. Northern Fire Equipment Corporation will be at the facility to inspect the system on 10/07/2014 Completed with no new issues. No other fire suppression systems are located in the facility. The Environmental Director or designee will ensure that the system is inspected every 6 months. Northern Fire Equipment has placed the facility on an every 6 month rotation to ensure continued compliance. Results of inspection will be reported to the QA Team on an on-going basis	11/15/2014

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	staff were observed. Findings include: Based on a observation, record review and interview between 11:00 a.m. and 3:00 p.m., on 10/16/14 with the maintenance director: the facility had no documentation to show the Engineered Restaurant Fire Suppression System had been recently inspected. The Maintenance Director also stated that he had no record or recalled if the past six month inspection was conducted. The maintenance director acknowledged the aforementioned deficiencies. 3.1-19(b)			
K010074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture			

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	within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure decorative hanging curtains were rendered flame resistant in 1 of 5 smoke compartments. LSC 19.7.5.1 requires draperies, curtains, including cubicle curtains, and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice effects residents, visitors, and staff in Units 2 and 3 and the main dining room smoke compartment. Findings include: Based on observation and interview with the maintenance director on 10/16/14 between 11:00 a.m. and 3:00 p.m., There were two large blue plastic tarps hanging from the dining room ceiling to the floor, which obstructed the sprinklers. Each	K010074	The facility will ensure that decorative hanging curtains are fire resistant The decorative hanging curtains that were in place for a haunted house have been removed. No other decorative hanging curtains are in the facility. Environmental Director or designee will ensure that during feature events that materials used are fire resistant per policy. The Environmental Director or designee will audit materials used in future special events to ensure that all materials meet regulation and facility policy. Results of audits will be reported the QA Team on an as needed basis.	11/15/2014

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	155530	A. BUILDING 01 B. WING	10/16/2014

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	tarp was approx 20' x 20' and enclosed an area of approx 20' x 40'. The maintenance director said at the time of observations, that this was temporary for a Halloween haunted house, he did not have evidence of flame resistance or treatment of the blue tarps. The maintenance director acknowledged the aforementioned deficiency. 3.1-19(b)			
K010154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on observation, record review and staff interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.7.6.1 in order to protect 69 of 69 residents. LSC 9.7.6.2 requires	K010154	The facility will have written procedures for emergency situations in the building. The policy identified has been updated with procedural steps to take when an emergency happens with the sprinkler system. Other emergency procedures have been updated to reflect procedural steps to take when emergencies occur. Staff will be in-serviced on procedural steps	11/15/2014

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	sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation, record review and interview with the maintenance director on 10/16/14 between 11:00 a.m. and 12:00 p.m., the facility had a document updated in 03/29/10 titled "Fire Watch Policy & Procedure" for a fire protection system failure but did not address all components of LSC Section 9.7.6.1. Specifically, the plan did not include verbiage specifically stating what to do when the sprinkler system for 4 hours or more in a 24 hour period is out of service. The maintenance director acknowledged the aforementioned deficiency. 3.1-19(b)		during an emergency. Policy reviews will be submitted to the QA Team for review. Environmental Director or designee will audit policies at least monthly to ensure that all policies have procedural steps. Results of audits will be reported to the QA Team on an on-going basis.	

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K010155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on observation, record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.6.1.8 in order to protect 69 of 69 residents. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation, record review and interview with the maintenance director on 10/16/14 between 11:00 a.m. and 12:00 p.m., the facility had a document titled "Fire Watch Policy & Procedure" for a fire alarm system failure but did not address all components of LSC Section 9.6.1.8. Specifically, the verbage of being out of service for more than 4	K010155	The facility will have written procedures for emergency situations in the building The policy identified has been updated with procedurals to take when an emergency happens with the sprinkler system Other emergency procedures have been updated to reflect procedurals to take when emergencies occur Staff will be in-serviced on procedural steps during an emergency. Policy reviews will be submitted to the QA Team for review Environmental Director or designee will audit policies at least monthly to ensure that all policies have procedural steps. Results of audits will be reported to the QA Team on an on-going basis.	11/15/2014

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	hours in a 24 hour period. The maintenance director acknowledged the aforementioned deficiency. 3.1-19(b)			